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Issue date: 19Nov2002

CASE NO.: 1994-BLA-1240

BRB Nos.: 00-0183 BLA
00-0183 BLA/A

IN THE MATTER OF:

CALVIN E. CLINE, SR.
Claimant

v.

WESTMORELAND COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR
Party-in-Interest

DECISION AND ORDER ON SECOND REMAND - DENYING BENEFITS

Claimant appealed this Court's Decision and Order on Remand Denying Benefits issued April 14, 1999 on a claim filed pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §901, **et seq.** (the Act).[1] This case involves a duplicate claim for benefits pursuant to 20 C.F.R. § 725.309(d)(2000). The Benefits Review Board affirmed in part, vacated in part and remanded the case for further consideration consistent with the Board's Decision and Order issued April 13, 2001.

[1]The Department of Labor has amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are codified at 20 C.F.R. Parts 718, 722, 725 and 726. All citations to the regulations, unless otherwise noted, refer to the amended regulations. Where a citation to the regulations is followed by "(2000)," the reference is to the old regulations.

In this Court's Decision and Order issued April 14, 1999 I found that the evidence developed since the denial of claimant's prior claim established that claimant suffers from a totally disabling respiratory or pulmonary impairment and thus demonstrates a material change in conditions as was required by 20 C.F.R. § 725.309(d)(2000). However, I found that the entire record did not establish the existence of either simple or complicated pneumoconiosis pursuant to 20 C.F.R. §§ 718.202(a), 718.304(a),(c)(2000). Consequently, this Court denied benefits.

The Board affirmed this Court's finding that claimant established total disability and attendant finding that a material change in conditions was established pursuant to Section 725.309(d)(2000). The Board noted this Court properly accorded greater weight to the opinions of Drs. Rasmussen, Fino and Daniel that claimant is disabled by his moderate lung impairment, because I found that they had more accurate knowledge of the physical efforts required by claimant's usual coal mine employment.

The x-ray evidence consisted of eighty-nine readings of fourteen chest x-rays taken over a seventeen year period. Of these readings, twenty-five were classified as positive for the existence of pneumoconiosis and forty-nine were classified as negative. Of the twenty-five positive classifications, twenty-four bore notations indicating the presence of Category A or Category B large opacities. Upon weighing and considering all the x-ray evidence, this Court found the x-ray evidence did not establish the existence of either simple or complicated pneumoconiosis, but rather, demonstrated the presence of abnormalities consistent with old tuberculosis. The Board noted, this Court did not ignore the readings of a May 13, 1994 CT scan but noted those readings and considered them in conjunction with discussing the physicians' x-ray readings and medical opinions. The Board concluded that this Court permissibly weighed the x-ray readings and found that the weight of the readings did not establish the existence of either simple or complicated pneumoconiosis. The Board also stated substantial evidence supports this Court's finding. Therefore, the Board affirmed this Court's finding pursuant to Section 718.202(a)(1),(3).

This Court additionally found the weight of the medical opinion evidence did not establish the existence of pneumoconiosis. Claimant contended and the Board agreed that this Court did not clearly apply the legal definition of pneumoconiosis in making this finding. As it was not clear that this Court also addressed whether claimant's obstructive lung disease constitutes pneumoconiosis under the Act, the Board vacated my finding pursuant

to Section 718.202(a)(4)(2000) and remanded the case for me to determine whether all of the relevant evidence establishes the existence of pneumoconiosis as defined in the Act.

ISSUES

Thus, the issues remanded for determination are

1. Whether the evidence is sufficient to establish that claimant suffers from pneumoconiosis as defined in the Act and regulations. 20 C.F.R. §718.202(a), 30 USCA § 923(b).

2. Whether the evidence is sufficient to establish that claimant is totally disabled, due at least in part to pneumoconiosis as defined in the Act. 20 C.F.R. § 718.204(c), 20 C.F.R. § 718.204(b)(2000).

3. Whether the evidence is sufficient to establish entitlement to benefits under the Act.

APPLICABLE LAW AND REGULATIONS

Claimant filed his duplicate claim on July 27, 1993 which is governed by Part 718 of the regulations. The amendments to Part 718 became effective on January 19, 2001 and are applicable to this case.

The amended regulations provide specific definition of "clinical pneumoconiosis" as distinguished from statutory or "legal pneumoconiosis." 20 C.F.R. § 718.201(a)(1)(2). The Act defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). A respiratory impairment arises out of coal mine employment if it is "significantly related to or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(b). **See Barber v. Director, OWCP**, 43 F3d 899, 900 (4th Cir. 1995).

The amended regulations provide this definition:

(a)(2) Legal Pneumoconiosis

> "Legal Pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment. 20 C.F.R. § 718.201(a)(2).

The case law of the United States Court of Appeals for the Fourth Circuit is applicable in this case.

MEDICAL OPINION EVIDENCE

Proof of Legal Pneumoconiosis - Section 718.202(a)(4)

Pursuant to Section 718.202(a)(4) the regulations provide a method for determining the existence of "legal pneumoconiosis", stating:

> (4) A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in §718.201. Any such finding shall be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

The record contains reports and/or depositions of nine physicians who have addressed the issue of whether Mr. Cline's coal mine dust exposure contributed to his chronic obstructive pulmonary disease (COPD). The Benefits Review Board had noted:

> Here, in addition to diagnosing simple and complicated coal workers' pneumoconiosis, Drs. Zaldivar and Rasmussen diagnosed chronic obstructive pulmonary disease, due in part to coal dust exposure. Claimant's Exhibits 7, 11. Dr. Rasmussen cited several medical studies which he stated establish that coal mine dust exposure causes clinically significant obstruction. Claimant's Exhibits 8, 13, 14. By contrast Drs. Crisalli, Morgan, Fino, Renn, Loudon, Stewart, and Daniel concluded that claimant's obstructive disease is due to his prior cigarette smoking habit. Director's Exhibits 13, 52A, 59; Employer's Exhibits 1,2, 5-9, 11. Dr. Fino criticized the medical studies relied upon by Dr. Rasmussen. Employer's Exhibit 9 at 30-33. Board Decision and Order at 8.

The Board further stated that while this Court's analysis "was proper as far as it went", citing **Island Creek Coal Co. v. Compton,** 211 F3d 203 (4th Cir. 2000), "it is not clear that the administrative law judge also addressed whether claimant's obstructive lung disease constitutes pneumoconiosis under the Act. See 20 C.F.R. § 718.201(a)(1),(2).

Sufficiency of Medical Opinion Evidence To Establish Legal Pneumoconiosis under Section 718.202(a)(4).

Claimant introduced his argument by stating "The preponderance of the medical evidence which is credible and consistent with the Act and regulations establishes the claimant's dust exposure in his coal mine employment significantly contributed to his chronic obstructive pulmonary disease." Claimant's Brief at 14. Claimant contends the most probative opinions on the issue of the relationship of the claimant's coal mine dust exposure to his obstructive lung disease are those written by Dr. Zaldivar and Dr. Rasmussen.

Employer contends "the preponderance of the medical opinion evidence establishes the claimant does not have legal pneumoconiosis. Rather, his obstructive impairment resulted from his long history of cigarette smoking." Employer notes claimant testified he smoked a pack to a pack and a half a day for about 32 years, from 1942 to approximately 1972. Employer's Brief at 7. Employer gives greatest weight to examining physicians Drs. Renn and Crisalli whose opinions are wholly supported by the consulting physicians Drs. Fino, Stewart and Loudon. Employer's Brief at 7-9.

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As noted earlier in this decision, the physicians all agree that claimant suffers from an obstructive lung impairment but do not agree as to the cause or severity of this disease. In various degrees, the opinions of Drs. Villaneuva, Green, Zaldivar and Rasmussen serve to favor finding claimant's chronic obstructive pulmonary disease is attributable at least in part to his coal dust exposure. Whereas, Drs. Crisalli, Morgan, Fino, Renn, Loudon, Stewart and Daniel ultimately concluded that Mr. Cline's obstructive disease is attributable to and resulted from his prior cigarette smoking habit.

The statute governing evidence required to establish a claim for black lung benefits states that "in determining the validity of claims...all relevant evidence shall be considered." 30 USCA § 923(b). Accordingly on remand of this case this court must weigh the x-ray evidence with the physicians' opinions to determine whether Mr. Cline has established the existence of pneumoconiosis by a preponderance of all of the evidence.

The United States Court of Appeals for the Fourth Circuit noted in deciding **Island Creek Coal Co. v. Compton**, 211 F.3d 203,

211 (4th Cir. 2000) that it is the province of the Administrative Law Judge to evaluate the physicians' opinions.

> "[A]s trier of fact, the Administrative Law Judge is not bound to accept the opinion or theory of any medical expert. **Underwood v. Elkay Mining Inc.,** 105 F3d 946, 949 (4th Cir. 1997). The Administrative Law Judge must examine the reasoning employed in a medical opinion in light of the objective material supporting that opinion, and also must take into account any contrary test results or diagnoses. **See Director, OWCP v. Rowe,** 710 F.2d 251, 255 (6th Cir. 1983)." **Id.** at 211.

Dr. Villaneuva examined the claimant on July 2, 1980. DX 19. Dr. Daniel diagnosed pneumoconiosis based on x-ray evidence and chronic obstructive pulmonary dysfunction. He gave no further explanation whatsoever for checking the "yes box" on the form responding to the question whether in his opinion the diagnosed condition related to dust exposure in the miner's coal mine employment. I give no weight to Dr. Villaneuva's opinion (as stated therein by Dr. Daniel) as it is not reasoned, lacks objective test data support and is conclusory.

Dr. Ronald W. Green, claimant's treating physician presents a brief comment in his "short letter" dated January 11, 1995 wherein he states "...I feel that it is consistent that he does have pneumoconiosis and suffers from chronic obstructive lung disease." The doctor provides no supportive test data, x-ray findings or pulmonary function studies. He fails to even mention claimant's smoking history nor does he clarify the etiology of the chronic obstructive lung disease. I find his opinion and comments are conclusory, completely not documented, lacking in adequate explanation and fail to provide a well reasoned opinion. I give no weight to Dr. Green's opinion of the etiology of claimant's chronic obstructive lung disease.

Dr. Daniel examined the claimant on September 8, 1993. DX 13. He diagnosed pneumoconiosis based on chest x-ray and chronic obstructive pulmonary disease based on abnormal vent studies. He reported the etiology of his diagnosis:

1. CWP - Etiology = inhalation of coal dust
2. COPD - Etiology = smoking cigarettes for 30 years

This court finds Dr. Daniel attributes claimant's obstructive defect to his cigarette smoking. Dr. Daniel based his diagnosis of pneumoconiosis on positive readings of chest x-ray which were refuted by highly qualified readers. Accordingly, I find Dr.

Daniel's opinion does not support finding Claimant's COPD was attributable to coal dust inhalation and cigarette smoking. His opinion fails to support a finding of legal pneumoconiosis.

Dr. Zaldivar examined claimant on April 19, 1989. His review of medical evidence included reports by Drs. Villaneuva, Daniel, Crisalli, Fino as well as chest x-ray interpretations. His conclusion stated:

> ...In my opinion, Mr. Calvin Cline has simple and complicated pneumoconiosis. He does have ischemic heart disease according to the new electrocardiographic findings in spite of absence of symptoms. He has moderate airway obstruction with moderate diffusion impairment. The obstruction may be due to cigarette smoking and coal worker's pneumoconiosis. However, the diffusion impairment together with the low residual volume is due to the presence of complicated pneumoconiosis. CX 11.

The Board affirmed this Court's finding the evidence was not sufficient to establish the existence of simple pneumoconiosis or complicated pneumoconiosis. This court noted that several physicians attributed significance to the family history of tuberculosis. Dr. Zaldivar was not informed of such fact as he reported "Family Illnesses: There is no family history of asthma, emphysema or heart disease." Thus the question arises what impact would the family history of tuberculosis have had upon Dr. Zaldivar's interpretation of x-rays he found demonstrated complicated pneumoconiosis. Additionally Dr. Zaldivar's conclusion, that Mr. Cline's moderate airway obstruction was due to both cigarette smoking and coal workers' pneumoconiosis, has been challenged and refuted by equally qualified examining physicians and reviewers which I discuss below. Accordingly, I give less weight to Dr. Zaldivar's opinion. I find his opinion relating to the etiology of claimant's obstructive lung impairment is outweighed by the well reasoned opinions of equally qualified lung specialists.

Dr. Rasmussen examined claimant on September 19, 1994 (CX 7). Chest x-ray (read by Dr. Patel) showed changes "which were quite consistent with complicated coal workers' pneumoconiosis," which arose from his coal mine employment. He noted claimant had two obvious risk factors for his disabling respiratory insufficiency, his coal mine dust exposure and his cigarette smoking. Dr. Rasmussen stated "...His coal mine dust exposure must be considered at least a major contributing factor."

Dr. Rasmussen's review of the medical evidence dated January 12, 1995 included reports by Drs. Fino, Renn, Stewart and Crisalli. The CT scan evaluation by Dr. William Scott and Paul S. Wheeler from a study of May 13, 1994 was also included. CX 8. Dr. Rasmussen noted

> ....the multiple readings of x-rays in this case, none of which indicate the presence of pneumoconiosis except for the study of Dr. Patel. The CT scans suggest primarily a granulomatous disease rather than complicated pneumoconiosis.
>
> In spite of the absence of x-ray changes felt compatible with pneumoconiosis by majority of observers, one is not able to exclude either the presence of coal workers' pneumoconiosis nor an effect of coal mine dust exposure on this patient's pulmonary function. CX 8 at 2.

Dr. Rasmussen also noted the CT scan was not high resolution and therefore "cannot be used to exclude the presence of pneumoconiosis. The x-ray itself is known to be incapable of excluding the presence of significant pneumoconiosis." As he noted claimant's significant smoking history, Dr. Rasmussen asserts "it is not possible to separate the effects of cigarette smoking from that of coal mine dust exposure. Therefore, I disagree with the opinions of Drs. Renn, Stewart, Fino and Crisalli." Dr. Rasmussen concluded claimant's chronic lung disease is the consequence of his cigarette smoking and his coal mine dust exposure. In support of his opinion and diagnosis Dr. Rasmussen noted that "There is also a large body of evidence confirming the fact that coal mine dust exposure is quite capable of producing disabling chronic obstructive lung disease including pulmonary emphysema."

This court has carefully reviewed Dr. Rasmussen's reports and finds his opinion, on the issue of etiology of claimant's obstructive impairment attributable to coal dust exposure, is not persuasive. Dr. Rasmussen insists on crediting the reliability of the positive x-ray readings notwithstanding the preponderance of the negative readings by experts and compatibility of changes with tuberculosis. He underscores his conclusion asserting "it is not possible to separate the effects of cigarette smoking from that of coal mine dust exposure." Other pulmonary specialists disagree with Dr. Rasmussen's concept of such an irrebuttable presumption of legal pneumoconiosis. Dr. Stewart stated it is possible to distinguish between impairments caused by cigarette smoking and those caused by coal dust exposure with a reasonable degree of medical certainty and explained the basis for that distinction. EE 5. Dr. Fino explained how the medical evidence in this case

affirmatively demonstrated obstructive impairment due to smoking and was not attributable to claimant's exposure to coal mine dust. EX 9. Although Dr. Rasmussen had knowledge of claimant's improvement after bronchodilator he made no attempt to reconcile such evidence with his opinion that claimant's obstructive impairment must be attributed to legal pneumoconiosis which is an irreversible disease unresponsive to medication. Dr. Rasmussen rejects the CT scan for not qualifying as "high resolution" and therefore cannot be used to exclude the presence of pneumoconiosis. However, he noted that "the CT scans suggest primarily a granulomatous disease rather than complicated pneumoconiosis." The court notes the CT scan evidence was not a determinative factor but, as noted by Dr. Fino, provided more views and more detail on the views to the examining and consultant pulmonologists. The CT scan merits consideration as it clearly constitutes "relevant evidence" on the issue of legal pneumoconiosis in this case.

This court finds Dr. Rasmussen's opinion relating to etiology of claimant's obstructive lung impairment is outweighed by substantial evidence which supports the opinions of pulmonary specialists Drs. Crisalli, Morgan, Fino, Renn, Loudon and Stewart. I find Dr. Rasmussen's reasoning in concluding claimant suffers from legal pneumoconiosis is not persuasive. This court's careful study of "all relevant evidence" relating to the issue of etiology in this case discloses presence of medical evidence which the vast majority of pulmonologists agree reliably supports their medical conclusion that claimant does not suffer from simple pneumoconiosis, or complicated pneumoconiosis nor from "legal pneumoconiosis."

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Dr. Crisalli reviewed the medical evidence listed in his report dated December 22, 1994 EX 5, 8. His review included reports by Drs. Fino, Daniel, Renn, x-ray readings and CT scans. Based on all of the data available, he found that there was not sufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis. He stated "I have changed my opinion in this regard due to the massive amount of x-ray data including CT scans which indicates that there is no occupational pneumoconiosis present." He found claimant does have a mild degree of pulmonary function impairment which is secondary to Mr. Cline's bullous emphysema and hyperreactive airways disease "which undoubtedly have resulted from his tobacco smoking over the years." I give weight to Dr. Casalli's opinion as it is well reasoned, consistent with the medical evidence he reviewed and also obtained upon his examination of Mr. Cline.

In his report dated April 28, 1989, Dr. Morgan reviewed the report from Dr. Zaldivar dated April 21, 1989. Dr. Morgan explains why the series of chest x-ray films do not support finding claimant suffered from simple pneumoconiosis or complicated pneumoconiosis. Dr. Morgan agreed that Mr. Cline "has mild to moderate airways obstruction with a similar reduction of his diffusing capacity." In his opinion, these impairments are the consequence of Mr. Cline's prior habit of cigarette smoking. He "did not believe that they are a consequence of his prior exposure to coal mine dust." Dr. Morgan further added that while Dr. Zaldivar read the large opacities as category A, "this early stage of complicated pneumoconiosis, i.e. category A is not associated with either ventilatory impairment or a reduction of the diffusing capacity", as was diagnosed by Dr. Zaldivar. In his interpretation of chest x-rays and the CAT scan Dr. Morgan reported on January 19, 1995 the few nodules that were present in the upper lobes "are much more likely to be due to either tuberculosis or more probably histoplasmosis." He also noted the evidence of emphysema. I give great weight to Dr. Morgan's assessment of Dr. Zaldivar's opinion relating to the issue of complicated pneumoconiosis. Dr. Morgan's finding no radiographic evidence of simple or complicated pneumoconiosis was confirmed by a preponderance of all the clinical evidence.

While Dr. Zaldivar relied to a large extent upon his positive interpretation of simple or complicated pneumoconiosis, his conclusion relating to etiology is contained in his ambiguous statement "...The obstruction may be due to cigarette smoking and coal worker's pneumoconiosis". CX 9 at 3. Whereas Dr. Morgan admitted the complexity of interpreting the radiographic evidence of chest x-rays in this case, he fully explained how the evidence supported his opinion that Mr. Cline's mild to moderate airways obstruction and reduced diffusing capacity are a consequence of his prior cigarette smoking habit. I find Dr. Morgan's opinion is well reasoned, fully documented and supported by substantial evidence. His qualifications as a pulmonologist provide reliability to his opinion.

Dr. Fino provided several reports and also explained his findings, diagnoses and opinions at his deposition held on February 2, 1995. (EX 9) Dr. Fino describes how the medical evidence in this case demonstrates the claimant's obstructive lung impairment is caused by cigarette smoking and cannot be the result of coal dust or coal mine dust exposure. Dr. Fino in effect contradicts Dr. Rasmussen's declaration that "one is not able to exclude either the presence of coal workers' pneumoconiosis nor an effect of coal mine dust exposure on this patient's pulmonary function." Dr. Fino points to the existing medical evidence which permits the

pulmonologists to discern a medical condition is established which excludes, with a reasonable degree of medical certainty, the existence of legal pneumoconiosis and/or clinical pneumoconiosis in this patient. Dr. Fino notes the CT scan gives a lot more specific information about what is going on within the lung tissue. He notes the changes evidenced by x-ray are not consistent with what has been described in the medical literature. Dr. Fino states claimant's extensive bullous emphysema is not the type of emphysema associated with coal mine dust inhalation or coal workers' pneumoconiosis. Depo. at 15. Dr. Fino found significant importance that Dr. Renn's vent study results yielded marked improvement in claimant's obstructive lung impairment after bronchodilators. He explains that pneumoconiosis is a fibrotic condition and as such would not respond to bronchodilators. **Id.** at 36-41. I give great weight to Dr. Fino's opinion relating to etiology of claimant's obstructive lung impairment. I find his opinion is well reasoned, well documented and is based on probative objective test data. Contrary to claimant's contention Dr. Fino did not premise his opinion upon an erroneous concept that coal workers' pneumoconiosis cannot produce an obstructive lung disease impairment. Nor does Dr. Fino restrict his analysis to clinical or medical pneumoconiosis. I find Dr. Fino's opinion relating to etiology of claimant's lung disease and impairment is adequately supported by his detailed consideration of the essential elements of legal pneumoconiosis contained in the voluminous record of this case.

Dr. Renn examined claimant on May 13, 1994. EX 2. He administered pulmonary function studies, blood gas studies and a diffusing capacity test. Dr. Renn interpreted the PFS demonstrated a moderate obstructive ventilatory defect which significantly improves following inhalation of bronchodilators. Mr. Cline's diffusing capacity was moderately reduced and remained so when corrected for alveolar volume. Based upon his examination of claimant and review of all the medical evidence available to him, Dr. Renn concluded that Mr. Cline has inactive pulmonary tuberculosis and bullous emphysema caused by his years of tobacco smoking. EX 2, 7.

Claimant contends Dr. Renn's opinions are conclusory and are based upon assumptions which are contrary to the Act and regulations. Claimant's challenge is without merit. At his deposition on March 10, 1995 (EX 11) Dr. Renn explained how the medical evidence established etiology of the lung impairment was due to both inactive pulmonary tuberculosis and emphysema with bronchospasm. He explained that a bronchospastic component to claimant's obstructive airways disease "is not consistent with coal workers' pneumoconiosis or any coal mine dust-induced disease but

is consistent with some forms of emphysema and with other bronchospastic airway disease. **Id.** at 20-21. Dr. Renn noted claimant's reduction in diffusing capacity most likely was due to his parenchymal disease destruction, a combination of the emphysema and also the tuberculosis. **Id.** at 24. Dr. Renn finds it significant that "you can appreciate the emphysema associated with diseases caused by tobacco smoking by the chest radiograph; whereas, you can't appreciate the focal emphysema of coal workers' pneumoconiosis by plain chest radiograph." **Id.** at 26-27. The doctor discussed the purpose of the CT scan was to determine more specifically the etiology of the masses in the upper zones than it was for purpose of determining whether or not simple pneumoconiosis was present." **Id.** at 20. Dr. Renn indicated he believed "this gentleman does not have coal workers' pneumoconiosis, or any chronic dust disease of the lungs arising out of his work in and about the coal mines." **Id.** at 29.

I give great weight to Dr. Renn's opinion relating to the issue of "legal pneumoconiosis." It is clearly apparent to this court that Dr. Renn based his opinion relating to the etiology of claimant's obstructive pulmonary disease upon all the medical evidence he obtained upon his examination of the claimant as well as upon the medical reports and evidence he reviewed. I find his opinion is well reasoned, fully documented and supported by objective medical evidence. Dr. Renn's qualifications provide strong reliability to his opinion and conclusions.

Dr. Loudon reviewed all the evidence listed in his report dated January 22, 1995. (EX 7) He opined claimant had a mild degree of pulmonary or respiratory impairment which he attributed to chronic obstructive lung disease, chronic bronchitis and emphysema, based on the radiological and pulmonary function test reports. He stated "coal workers' pneumoconiosis cannot be implicated in this mild degree of impairment, for the same reason." **Id.** at 7. In his opinion "the mild disability of the claimant is not caused either in whole or in part by pneumoconiosis." **Id.** Dr. Loudon also stated:

> My opinion on the cause of Mr. Cline's minor degree of pulmonary impairment would not change if the miner were found to have coal workers' pneumoconiosis. I based this opinion on the nature of the claimant's symptoms and signs, and on the pulmonary function test results showing a partly reversible obstructive impairment, not found in CWP. **Id.** at 7.

I give weight to Dr. Loudon's opinion of causality. He reviewed a vast amount of the medical evidence and found the "original data"

provided the basis for his own opinion. In effect Dr. Loudon finds the medical evidence excludes the claimant's coal mine dust exposure from participation in or contribution to his chronic obstructive lung disease, chronic bronchitis and emphysema. I find Dr. Loudon's opinion on the issue of the etiology of claimant's obstructive lung impairment is well reasoned, fully documented and is based on objective medical evidence. Dr. Loudon's qualifications extend much support to the reliability of his opinion.

Dr. Stewart reviewed the medical evidence in his reports dated October 5, 1994 (EX 5) and January 16, 1995 (EX 6). In his latest report Dr. Stewart stated the medical evidence indicates Mr. Cline does have a respiratory impairment which "is not caused in whole or in part from coal workers' pneumoconiosis or coal dust exposure, but instead is caused by his history of smoking cigarettes." EX 6 at 5. In discussing Mr. Cline's obstructive lung defect, Dr. Stewart stated

> ...It is my opinion that it is possible to distinguish between impairment caused by smoking cigarettes and those caused by coal workers' pneumoconiosis with a reasonable degree of medical certainty. Patients who are symptomatic from smoking cigarettes will have a reduced FEV_1/FVC ratio. This reduction indicates airway obstruction. Patients who are symptomatic, however, from interstitial lung disease will have, on the other hand, reductions in forced vital capacity or total lung capacity testing. In Mr. Cline's case, the ratio of FEV_1/FVC is reduced. As stated, both FVC and TLC are within normal limits. EX 5 at 9.

Dr. Stewart concludes his report stating

> If this miner was indeed found to have coal workers' pneumoconiosis, it would not change my opinion regarding his disability or impairment causation. As I noted above, it is my opinion that it is possible to distinguish between impairments caused by coal workers pneumoconiosis and those caused by smoking cigarettes. Mr. Cline's impairment was related to smoking.

CONCLUSIONS

Upon further consideration of all the medical opinions this court finds the evidence is not sufficient to establish the existence of "legal pneumoconiosis." The Board affirmed this court's finding claimant does not suffer from simple pneumoconiosis

nor from complicated pneumoconiosis. Claimant in order to prevail in this claim for benefits, has the burden of proving by a preponderance of the evidence, that he suffered from pneumoconiosis as the disease is defined in the Act. Upon establishing statutory pneumoconiosis claimant must then show the pneumoconiosis contributed at least in part to his disability.

This court finds the opinions relating to causality of claimant's obstructive lung disease by Drs. Villaneuva, Green, Rasmussen and Zaldivar are outweighed by the better reasoned and documented opinions of Drs. Crisalli, Morgan, Fino, Renn, Loudon, Stewart and Daniel, all of whom are Board certified pulmonologists. While Dr. Zaldivar also is a Board certified pulmonologist and Dr. Rasmussen specializes in pulmonary abnormalities, I found their opinions and medical reports less persuasive as discussed supra (and as considered in this court's prior decision pages 22 to 26).

I give greatest weight to the opinions of Drs. Renn, Fino, and Stewart who are supported by the opinions of Drs. Crisalli, Loudon and Morgan.

Claimant has failed to establish by preponderance of the evidence that he suffers from statutory pneumoconiosis. Failure to establish this essential element of entitlement precludes the award of benefits. Accordingly his claim for benefits is disallowed.

DECISION AND ORDER

It is ORDERED that the claim of **CALVIN E. CLINE, SR.**, for benefits under the Act, is **DENIED**.

A

CLEMENT J. KICHUK

Administrative Law Judge

CJK:dr

NOTICE OF APPEAL RIGHTS

Pursuant to 20 CFR §725.481, any party dissatisfied with this Order may appeal it to the Benefits Review Board within 30 days from the date of this Order by filing a Notice of Appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Francis Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.